(and the villagers) determine are essential for their job. These tasks (behavioral objectives) are to be defined before training begins, and the curriculum should be structured so that all the behaviorial objectives can be achieved.

(2) Training should take place in an environment similar to the one the VHWs will be working in when they return to the village.

(3) Training should take place in relatively brief segments (e.g., 2-3 weeks at one time) with regular and frequent "continuing education" and further training.

(4) Training should, as much as possible, be "practical" and fieldwork oriented rather than theoretical and didactic.

(5) During training there should be continous feedback to the students regarding their competency, and there should be "built-in" evaluation to allow the teachers to know whether the educational objectives are being met.

Initial training of the VHWs should take place at a BHC and in a nearby village. Training at the BHC should be the responsibility of the BHC staff and an MOPH training team. A well defined curriculum must be completed before training begins. If illiterate VHWs are to be trained, a curriculum for illiterates will be developed.

The curriculum will be divided into units, the teaching location (village or BHC) depending on the nature of the subject. The units will cover areas such as hygiene and sanitation, nutrition, first aid, treating common symptom complexes, family health, etc. Each unit will have its own behavioral objectives, teaching materials (including visual aids) and fieldwork component.

During the period of village training the BHC staff will rotate through the village so that they will be able to observe the VHWs in a village setting and so that they will be able to help with teaching. The MOPH VHW training team (composed of at least one Sanitarian and Nurse-Midwife) will be with the VHWs in both the BHC and village phases of their training.

The follow-up training and continuing education should occur at regular intervals (such as one weekend every three months), the exact interval depending on the situation of the particular group of VHWs. This continuing education will take place both at the BHC and in villages. It will emphasize the practical problems encountered by the VHWs in their villages as well as suggestions for solutions to those problems. Additional skills that were not taught during the initial training can be taught during these periods of continuing education.

Training can also take place in more specialized areas. For example, female VHWs could be provided with midwifery training at the Maternity Hospital. On the other hand, male VHWs could be given practical training in orthopedics by the local shikistaband or the orthopedics department at Wazir Akbar Khan Hospital.

D. Supervision

Five separate levels of supervision are involved with VHWs. These are:

(1) Village level supervision (by village leaders, Village Committee). Supervision at the village level is primarily involved with "managerial supervision" (for example, making sure that the VHW is charging the correct fees, that he/she is not giving injections to every patient regardless of symptoms, etc.). This level of supervision is the most important; if the village does not carefully

watch its VHW, many problems will be created.

(2) BHC level supervision (supervision by existing BHC staff or by BHC staff newly appointed to supervise VHWs). Supervision from the BHC could be done by the BHC Sanitarian if he has sufficient time. The job would primarily involve regular village visits to provide continuing education and to make certain that more complicated problems are being referred to the BHC. This level of supervision would be primarily "technical supervision." The BHC physician, nurse, and/or ANM could also assist in supervision. If one of the VHWs is found to be excellent after three to four months of work, he or she could be trained to be a VHW supervisor.

(3) PHO level supervision (may be considered when province-wide implementation is begun). The PHO, in his role as responsible medical officer of the province, can help supervise the BHC staff in their role as supervisors.

(4) Regional level supervision (when regional training centers are completed). This level and PHO level supervision constitute supervision of supervisors.

(5) National (Kabul) level supervision. This level of supervision would involve MOPH involvement in the overall VHW supervision process.

It is clear that the villages must assume a great deal of supervisory responsibility (mostly administrative but technical also). This is so because many villages will be isolated from the BHC and from Kabul much of the time. Unless the Village Committee takes an active interest, the program will suffer greatly. It must be made clear to the village that they will receive no money from the government--rather, the government will train the VHW, help with initial supplies and provide the necessary follow-up support and technical

supervision. All other responsibilities must be assumed by the village itself.

E. <u>Supply</u>

Since most VHWs will live in villages that are quite isolated from BHCs, the problem of drug and equipment supply is particularly important. Several different methods of supply are being considered, and the first three VHW projects (each based at a different BHC) can each test a different supply system. In this way three different supply methods can be compared and information gained for future expansion of the VHW program.

The supply systems presently being considered can be described as follows:

(1) All drugs and equipment for the VHW would be procured and distributed in the same manner as is being developed in the BHC logistics system. From a central warehouse in Kabul or from a regional warehouse, drugs and equipment for VHWs will be distributed to those BHCs around which the VHWs are located. The drugs and equipment will be obtained either from UNICEF, the Avicenna Pharmaceutical Institute, or some other source of relatively inexpensive generic drugs. Once the drugs and equipment arrive at the BHC, they can be distributed to the VHW by the VHW supervisor (usually the BHC Sanitarian) or they can be picked up by the VHW himself/herself at the time of the quarterly in-service training sessions conducted at the BHC.

(2) An alternative system for supplying drugs and equipment for the VHW can be carried out through the <u>dokan</u>, or village shop. In many villages where VHWs will be located there exist small shops which sell a variety of items, including over-the-counter medications, such as aspirin. Since they already have a system for obtaining these items

(from a provincial town or else from Kabul), it might be possible to distribute drugs and equipment to the VHW using the dokandar's distribution system. The dokandar could receive a small fee for handling the material and for his role as "middle man". In some cases the VHW's village has no dokan. Where this occurs a dokan in the town where the BHC is located could serve as the distribution point from which the VHW could pick up his/her drugs and equipment.

(3) Still another system of distribution could bypass both the dokan and the BHC by having the drugs and equipment distributed directly from Kabul to the VHWs. Though more expensive and more time consuming than the previous two alternatives, this system has the advantage of having no middle man. Distribution takes place direct from warehouse to VHW.

By comparing the results of these three systems, recommendations can be made for efficient distribution in an enlarged VHW program.

F. Financing and Management System

Just as in the case of supply, the financing of the VHWs' activities (including payment to the VHW for his/her services, as well as payment for drugs) can be handled in several different ways. However, our proposal for financing the VHWs is based on having the village determine how the VHW will be paid, rather than having the MOPH decide. The village can use or combine any or all of the following three basic payment mechanisms:

(1) Each time a sick villager visits the VHW, he could pay the VHW a small fee (amount decided by the village) for his services. This would be one source of income for the VHW.

(2) Each time the VHW provides drugs to a villager, the VHW could be paid a certain amount for the drugs. The price for each drug can be determined in advance by the village. In this way, the VHW makes a small profit from the drugs he prescribes, and at the same time the initial cost of the drugs can be retrieved so that a new supply of drugs can be obtained. (It should be noted that the first stock of drugs provided to the VHW will be given "free." When these drugs are sold to villagers the money received can be used to purchase a new supply of drugs. In this way the village can always have a supply of drugs on hand to treat simple, common village illnesses.)

(3) The village can require every household to pay a certain number of afghanis each month in a kind of insurance system. This money can be given to the VHW to provide a salary, while at the same time, it enables each family which pays its monthly fee to be guaranteed access to the VHW's services and drugs. An insurance scheme could conceivably be used to pay for drugs as well.

The money for drugs will flow in the following way: When the VHW has sold a substantial proportion of his drugs, he will take the money he has collected to the BHC. At the BHC he will present his list of needed drugs (replacing the drugs he has sold), and he will pay for them with the money he has brought with him. The money will then be taken by the BHC to the man handling financial matters for the <u>woleswali</u>. The money will then be deposited in a special account for VHWs. (The account should be in the name of the Ministry of Public Health. The MOPH will then transfer the money to UNICEF, reimbursing UNICEF for the drugs they have provided.) If there is a branch bank in the <u>woleswali</u> center the money

can be deposited locally. Otherwise, the money will be sent to the provincial capital or to Kabul for deposit.

G. Continuing Education

The 2-3 week training course given to all VHWs represents only the core material they are to learn. Of equal, if not greater, importance is the in-service and continuing training they must receive on a regular basis. The VHWs will be visited in their villages by their supervisor from the BHC (who will review problems and do basic teaching), but the VHWs should also return regularly to the BHC for refresher training. This continuing education can occur quarterly for at least 2-3 days each time. New skills will be introduced, and skills already learned will be reviewed and discussed. At the same time, the VHWs can compare experiences and learn a great deal from each other. Depending on how quickly the VHWs are able to put what they have learned into practice, the sessions at the BHC can be adjusted accordingly.

H. Evaluation

A crucial aspect of the beginning phase of the VHW program is evaluation. A major purpose of the first three "projects" (at three different BHCs) is to compare different methods of training, financing, supervising, etc. so that recommendations can be made for successful expansion of the VHW idea. Useful recommendations can only be achieved if a properly designed and executed system of program evaluation is established and incorporated into the program from its outset. At least four different kinds of evaluation will be included.

(1) A survey will be performed in all villages which will have a VHW. This survey (completed before the VHW begins work) will measure the knowledge, attitude, and practice of the villagers regarding

health. After the VHW has been working 18 months to 2 years in the village, the survey will be repeated. In this way, any improvement in the villagers' knowlege, attitude, or practice (KAP) concerning health can be ascertained. In order to be certain that whatever improvement might be found is, in fact, the result of the VHW's efforts, a survey of "control" villages will be conducted that will be identical to the survey carried out in the VHW villages. The control villages will be chosen in such a way that they are similar to the VHW villages in every significant respect. The only difference will be that the "control" villages have no VHW. Thus, if there is an improvement in the VHW villagers' health KAP but no improvement in the "control" villagers' KAP, it can be concluded that the improvement is most likely due to the work of the VHWs.

(2) Certain "output" and "impact" variables will be evaluated. These will include the number of patients seen by the VHWs, the weights and arm circumference measurements of village children (to measure nutritional status), the number and type of drugs prescribed by the VHWs, the number of home visits made, latrines built, and the number of contraceptive acceptors. In this way some understanding will be gained of the actual work done by the VHWs. At the same time, the number of referrals made to the BHC by the VHW, and the number of births and deaths in the village (recorded by the VHW) will help in the analysis of VHW performance.

(3) A third form of evaluation will look at the organizational structure of the projects, including the success or failure of the systems for supply, supervision, finance, continuing education, etc. For example, by comparing the experiences with

different methods of supply for the different VHW projects, an optimum supply system can be determined. Similarly, the most effective financing mechanism for future VHW programs can result from analysis of the different experiments going on in different villages.

(4) Yet another form of evaluation will examine the level of village interest in the VHWs by means of surveys, in-depth interviews and village discussions. Also the effectiveness of the village committees will be looked at closely. By measuring the degree of village satisfaction with the VHW, we will be able to establish VHW programs in the future which more closely meet the needs of the people.

V. Program Phasing (Including Expansion)

The VHW program is planned to start slowly and carefully, so that the MOPH can learn to develop the most effective way of bringing primary health care to villages. Also, by starting slowly, systematic evaluation of the program can provide a great deal of useful information for the future. In 1356, three BHCs will be chosen for the VHW program. It is expected that for each BHC about ten villages will be selected. Each village will be asked to send one man and one woman (possibly man and wife) to the BHC for training. It is assumed that, on the average, every village will send one man and half the villages will also send one woman. The projection for expansion of the program (assuming the first projects are successful in 1356) can be seen from Table I on the next page.

TABLE I

VHW PROGRAM - PROJECTED NUMBER OF BHCs, VILLAGES, AND VHWs

	1356	1357	1358	1359	1360	1361
No. of BHCs	3	10	20	32	46	60
No. of Villages	30	120	260	443	690	1000
No. of VHWs	45	180	390	565	1035	1500

Table I assumes that ten villages will initially send VHWs to the BHC for training. However, it is also assumed that each year the BHC will train additional VHWs from new villages. In this way we expect that the average BHC by 1361 will have trained VHWs from sixteen or seventeen villages. The expansion, therefore, is both an increase in the number of BHCs doing training and in the number of villages (and thus VHWs) per BHC.

The phases can be defined as follows:

1355 - PREPARATORY PHASE - including choosing BHC sites, training BHC staff, recruiting and selecting VHWs, developing training curriculum and materials, planning system of supply and supervision, etc.

1356 - EXPERIMENTAL PHASE - Three BHCs will be used as training sites for VHWs. Methods of training, recruitment, selection, supervision, and supply will be further developed for subsequent expansion of the program.

1357 - INITIAL EXPANSION PHASE - The program will be expanded to ten BHCs, based on what was learned in the first three centers during 1356.

1358-1361 - GENERAL NATIONAL IMPLEMENTATION - Expansion to sixty BHCs nationwide.

After the first projects have begun and evaluation is underway, there are several areas in Afghanistan where the VHW idea can be integrated into a larger system. These areas

A Proposed Village Health Worker Program for Afghanistan

I. Introduction

About 85% of the people of Afghanistan live in villages and towns without convenient access to primary medical care. The Republic of Afghanistan and its Ministry of Public Health (MOPH) consider as a matter of the highest priority the provision of adequate medical care to the entire population. A network of Basic Health Centers (BHCs) has been created in rural areas of the country (106 BHCs are now functioning), but the great majority of Afghanistan's 18,000 villages are located at long distances from a BHC.

If primary medical care is to be provided to the scattered village population, an alternative to the present health delivery system must be considered. The number of physicians is far too few to be able to provide medical coverage over so vast an area. Even if there were enough physicians, the lack of social and educational opportunities in the village for the physician and his family would keep them away. One alternative that has been attempted in a number of countries is that of the Village Health Worker (VHW). The basic idea involves the selection and training of a villager who is then able to treat the most common medical complaints in the village (referring all the more complicated cases to the BHC physician) as well as to teach his or her fellow villagers the rudiments of hygiene, sanitation, nutrition, etc. The VHW is supervised and supported by the nearest BHC, so that he becomes the village extension of the ongoing national health system.

If any VHW program is going to be successful in Afghanistan, it must be designed in such a way that it is compatible with Afghan culture and is acceptable to the Afghan village. In order to determine the attitude of Afghan

are the Helmand Valley and areas where Rural Development Department projects are being planned.

A. Helmand Regional Integrated Rural Health System:

The MOPH is planning an integrated system in the Helmand Region for rural health care delivery. It is expected that a Rank I Regional Training Center will be operating in Girishk (Helmand Province) in early 1356. This Regional Center will integrate health care delivery over a wide area. Soon after the Rank I Center begins functioning, it is hoped that VHWs (as well as traditional practitioners and other categories of health workers) can be trained there. The VHWs who cannot be initially trained in Girishk can be brought there for continuing education and "refresher courses." In this way the VHWs in the Helmand Region can be linked not just to the nearby BHC but also to the Regional Hospital and Training Center. The Regional Center makes possible a much more structured and integrated rural health delivery system in the Helmand Region.

B. Integrated Rural Development Projects:

The Rural Development Department (RDD) has planned several integrated rural development projects. These projects will try to improve village agriculture, education, and roads (as well as health care) in an integrated fashion, so that the people themselves determine their own needs and priorities and work together for their fulfillment. As part of these integrated schemes, health care delivery plays an important role. VHWs could be trained at RDD project sites and work in villages in cooperation with other categories of health workers. It is possible that VHWs could be trained in certain non-health areas (such as agriculture or education) since the RDD programs are multi-disciplinary and intersectorial. These are very important experiments, since integrated rural development, when it is possible, is preferable to unilateral development along traditional lines.

VI. Conclusion

There is a great need for primary health care in rural Afghanistan. The Village Health Worker will not be able to solve all village health problems, but if he or she is properly supervised and supplied, a major improvement in village health is possible. The proposal presented here is an attempt to create an Afghan solution to an Afghan problem. Although much has been learned from the experience of others, in China, Iran, Guatemala, Indonesia, and elsewhere, the conditions and culture of Afghan villages are unique. Afghan VHWs must be self-sufficient in that their work must be totally supported by their village. The government can, and must, assist in training, supervision, and supply; but the primary support, material and moral, must come from the villagers themselves.

If Afghan villagers have sufficient confidence that their VHW is a valuable person, then the program will succeed. The challenge lies in whether or not the MOPH can recruit the right persons and then train and supply them properly, so that the VHWs will be able to convince their fellow villagers to support them. A difficult job lies ahead, but it is a job that must be done.

APPENDIX A

VHW BUDGET 1356-1361

The VHW program must be financially self-sufficient if it is going to involve thousands of villages. As the program expands, drugs assume an overwhelming proportion of the total cost of the program.

Table II summarizes the estimated cost of the program for 1356-1361. Note that by 1361 nearly 90% of the cost is for drugs.

TABLE II

VILLAGE HEALTH WORKER BUDGET (AFS x 1000)

	1356	1357	1358	1359	1360	1361
Salaries	161	347	473	473	536	536
Training	90	270	420	564	726	930
Transport	134	268	336	463	470	470
Equipment	130	312	380	577	819	1,113
Per Diem	137	298	444	444	496	496
Total (without drugs)	652	1,495	2,053	2,521	3,047	3,550
Drugs	900	3,600	7,800	13,440	20,700	30,000
Total (including drugs)	1,552	5,095	9,853	15,961	23,747	33,550

A simple financial analysis of the VHW budget indicates that villagers must pay for their drugs if the program is to be financially self-sufficient. Since the drugs can be purchased cheaply (as generic drugs), the VHW can sell them at a lower price than pharmacies, and at the same time make a small fixed profit. If the MOPH provides the drugs to the VHW at a small profit to the MOPH, then the administrative costs of the program could also be covered and the entire program, including central-level administration, could be

self-sufficient.

If the MOPH considers paying salaries to VHWs, the cost becomes great as the number of VHWs increases. If 1,000 Afs per month were to be the salary, by 1361 a total of 18,000,000 Afs per year would be needed for 1,500 VHWs. However, the VHWs can be paid by the villagers themselves (as discussed in the "Financing and Management System" section). This would be consistent with the important principle of financial self-sufficiency for the entire VHW program.

villagers towards VHWs, the MOPH conducted a large scale village survey in August-October, 1976. A total of 486 women and 237 men were interviewed in 17 villages in the provinces of Ghazni, Baghlan, and Helmand. The villagers comprised a representative geographic and ethnic sample of rural Afghanistan so that their opinions reflect those of villagers throughout the country. When asked whether they thought VHWs would be suitable for their village (after the VHW concept had been explained to them), 95.2% of the women and 78.3% of the men agreed. Out of 723 persons interviewed, only one felt that medical care for his village was good enough at present so that a VHW was not needed. With this in mind and following extensive discussions with Afghan villagers, village leaders, and health officials, the following guiding principles for an Afghan VHW program have been established:

A. The Afghan VHW program must be primarily the responsibility of the individual villages involved. A village committee must choose its VHWs, supervise their activities, and determine and manage the financial aspects of the program.

B. The Ministry of Public Health of the Republic of Afghanistan has the responsibility for training the VHWs chosen by the villages, for supplying drugs and other material to the VHW (but not paying for them) and for technical supervision of the VHW (to be done by the BHCs).

C. The VHW program must be self-sustaining and self-sufficient. This means that the village must take sufficient interest in its own health so that the VHW program can continue without frequent government intervention.

D. The VHW program must be evaluated in such a way that lessons can be learned for the successful expansion of the concept to all provinces in the country. Since Afghanistan is so diverse in ethnic groups and

topography, each region must adapt the program to fit its own particular needs. Indeed, each village must modify those aspects of the program in consideration of its own specific situation.

E. The final guiding principle for the VHW program is the realization that progress and development in the village depend on much more than good health. Socio-economic development in the village requires improvement in agriculture and education, as well as health. The VHW must either learn additional skills or else integrate his activities with other village workers so that the village can develop in a balanced and integrated manner.

II. Program Objectives

The proposed VHW project has the following objectives:

A. To reduce the existing high levels of village morbidity and mortality by having VHWs provide preventive and curative care at the village level.

B. To help establish an integrated rural health delivery system with VHWs providing village primary medical care and with referral to more specialized care at sub-centers and Basic Health Centers. Also, to increase the efficiency and effectiveness of the BHC system by providing greater access to health care for those most in need.

C. To recruit, select, train, supervise, supply, evaluate, and provide continuing education for VHWs in 1,000 villages by 1361, and ultimately expand the program to most of Afghanistan's 18,000 villages.

D. To assist in the socio-economic development of Afghan villages by cooperating with other sectors, so that integrated village development can occur.

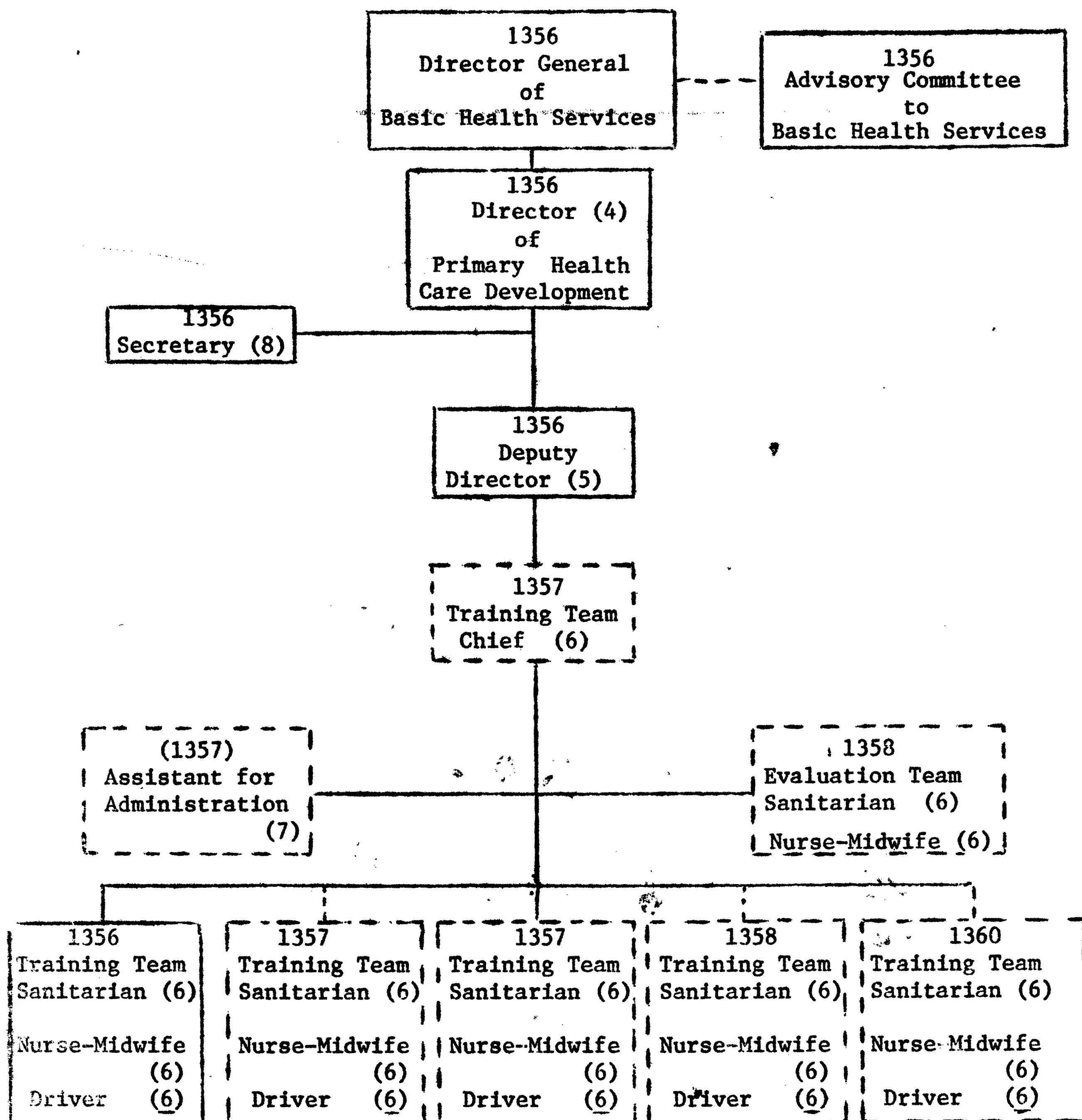
III. Program Organization

The Village Health Worker program will be administered by the MOPH through its Department of Preventive Medicine. The present plan is for the program to be organizationally part of the General Directorate of Basic Health Services. The Director of the VHW program will be called the "Director of Primary Health Care Development," and will serve directly under the General Director of Basic Health Services. When either the Institute for Health Manpower Development or Technical Support Services within the MOPH is able to develop standards for VHWs, then they will take over the training component of the program.

In order to provide the program with greater perspective, an Advisory Committee to the Director General of Basic Health Services will be able to assist in the management of the VHW program. The Advisory Committee should consist of the Director of Primary Health Care Development (Secretary of the Committee); the Presidents of the Kabul Maternity Hospital, the Public Health Institute, and the Child Health Institute; the Chief of the Nursing Division within the MOPH; and representatives from the Rural Development Department, UNICEF, WHO, and the Management Team.

In addition, a High Commission can be established to oversee the entire program. This commission might consist of the Minister of Public Health, the Minister of Agriculture, the Minister of Education, and the Minister of Interior. The membership of the High Commission can be revised according to circumstances.

As projected in the MOPH Seven Year Plan (1356-1361), the VHW program will have a Deputy Director appointed in 1356. The Training Team Chief (appointed in 1357) will be responsible for supervising the Training Teams (consisting of a senior Sanitarian and a Nurse-Midwife) to make sure that they effectively and efficiently train each new group of VHWs. In addition, it is expected that in 1358 an Evaluation Team will be created to insure that the quality of



1356
Director General
of
Basic Health Services
1356
Advisory Committee
to
Basic Health Services
1356
Director (4)
of
Primary Health
Care Development
1356
Secretary (8)
1356
Deputy
Director (5)
1357
Training Team
Chief (6)
(1357)
Assistant for
Administration
(7)
1358
Evaluation Team
Sanitarian (6)
Nurse-Midwife (6)
1356
Training Team
Sanitarian (6)
Nurse-Midwife
(6)
Driver (6)
1357
Training Team
Sanitarian (6)
Nurse-Midwife
(6)
Driver (6)
1357
Training Team
Sanitarian (6)
Nurse-Midwife
(6)
Driver (6)
1358
Training Team
Sanitarian (6)
Nurse-Midwife
(6)
Driver (6)
1360
Training Team
Sanitarian (6)
Nurse-Midwife
(6)
Driver (6)

VHWs being trained and supervised is maintained. As shown in the following organizational chart*, one training team is sufficient for 1356. As the program expands, however, the number of teams should increase so that by 1361 there should be five training teams. The administrative support staff, as well as cars and drivers, will also increase gradually as the number of VHWs being trained continues to expand.

IV. Program Plan

A. VHW Job Description

The VHW is primarily concerned with trying to change those habits of villagers which lead to disease and poor health. By means of health education and preventive measures, for example, the VHW tries to teach village mothers the importance of breast feeding and of supplementing breast milk with solid food by the time the infant is six months old. The VHW also demonstrates the value of personal hygiene, the use of soap, keeping flies from feces and other practices that will reduce the number of preventable deaths, especially among children under five years of age.

The VHW also treats those minor ailments that are common in the village. While treating a child with diarrhea, for example, the VHW also stresses the importance of continued food and liquids for the sick child. Of particular importance is the way the VHW deals with the fundamental values and beliefs of his or her fellow villagers. The VHW should not attack those beliefs. Instead, the new health practices introduced into the village should be considered an addition to pre-existing health practices and not as replacements.

*See chart next page (5a).

The VHW should understand at all times that he or she is not a doctor, and that all serious problems must be referred to the sub-center or Basic Health Center. The VHW's time and energy should be mostly spent on home visits, latrine building and similar measures rather than on the symptomatic treatment of disease. Only in that way can the fundamental village conditions, which lead to frequent and recurrent illness, be changed and a healthier village emerge.

B. Recruitment and Selection

Following completion of the Village Health Survey (conducted in villages in Baghlan, Ghazni, and Helmand Provinces, from August-October, 1976), the MOPH began visiting villages located 10-30 km. from selected BHCs in order to determine the level of village interest, and in order to help establish village committees. By December, 1976, two BHCs had been visited: Jaghori (Ghazni Province) and Sarobi (Kabul Province). It is proposed that in these and future village visits the objectives be the following:

(1) Discuss the project with the Provincial Governor, the Woleswal, and the BHC staff in order to obtain their cooperation.

(2) Discuss with as many villagers as possible the idea of the VHW. This discussion should include both potential benefits and risks to the village of this program.

(3) Explain the minimal requirements of the MOPH for potential VHWs. These requirements include:

(For Males)

a) Married.

b) Less than 40 years old.

c) Completed military service (or exempt).

d) In good health.

e) No vocation which would prevent him from working as a VHW.

f) Respected by other villagers and motivated to help his fellow villagers.

g) Literate.

(For Females)

a) Married.

b) Less than 50 years old.

c) Able to leave the village (accompanied by husband or male relative) for short periods for training.

d) Motivated to help fellow villagers.

e) Able to spend at least part time ($\frac{1}{2}$ day) working as a VHW.

f) In good health.

g) Intelligent (literacy not required).

h) Respected by other women in the village.

(4) Establish, with the cooperation of village and woleswal officials, a "Village Committee." This committee should be broadly representative of the village as a whole. The following factors should be taken into consideration in choosing the Village Committee:

a) At least 3 (but no more than 6) villagers should be chosen. The method of selection should be for the villagers to decide. A village meeting should first be held (attended by as many villagers as possible), in which the VHW program should be explained in detail.

b) The Village Committee should be "official." The names of its members should be recorded and brought to the Woleswal. Although unpaid, membership in the Village Committee should be considered an honor.

c) The members of the Village Committee must be sincerely interested in the welfare of their village and not just in private gain. Depending on their level of interest and commitment, the VHW program will succeed or fail.

The functions and responsibilities of the Village Committee should be explained. These include: .

a) Nominating (if possible) three men and three women who the committee feels would be excellent VHWs, using the minimal requirements listed above as a guide.

b) Supervising the managerial aspects of the VHW's work in the village.

c) Dismissing the VHW if he or she is inadequate and replacing the VHW with a new one.

An MOPH team should make several village visits (the exact number depending on the ease with which the Village Committee is formed, and the degree of its interest in and understanding of the VHW concept).

Criteria for village selection should include:

(1) Village should be about 10-30 km. from the BHC (Note : Where female VHWs are not available, villages nearer than 10 km. can be selected, if there are female VHWs available from these villages).

(2) Village should have between 50 and 200 households per male and female VHWs.

(3) Village should have an interest in VHWs.

Once the Village Committees have been formed and are functioning effectively, the next task of the MOPH team is to assist in the final village selection of the VHW. The nominees of the Village Committee should be interviewed (in the presence of the Village Committee), and the final selection should be made in collaboration with the Committee. Criteria to be used for selecting a VHW on the basis of the interview should include:

(1) Degree of motivation of the candidate to help his/her fellow villagers.

(2) General level of health. (Those selected must pass a physical exam demonstrating their fitness for the job.)

(3) Level of intelligence.
(4) Demonstration of level of literacy. (Minimal functional literacy is acceptable for men.)
(5) Work and/or family situation of the candidate. (It should be clear how much time can be spent away from the village for training, and how many hours per day can be spent working as a VHW after training is completed.)

After completion of the village interviews, a maximum of one male VHW and one female VHW will be chosen from each village. Before leaving the village, the MOPH team should make clear to the VHWs and Village Committee exactly when and where training will begin for the VHW and what the VHW should bring with him/her. Also, it should be understood by the Village Committee that the village is responsible for certain things if it is to have a VHW. These things include:

(1) Equipping and furnishing (simply and modestly) a one-room "clinic" for the VHW.
(2) Determining how the VHWs will be paid for their services.
(3) Supervising the financial and administrative aspects of the VHW's work.

By the end of 1355, the MOPH had made two visits to villages around both Sarobi and Jaghori BHCs. VHWs were chosen at both sites, and training is scheduled to begin for the first group of VHWs at Sarobi on 30 April 1977 (10 Saur 1356).

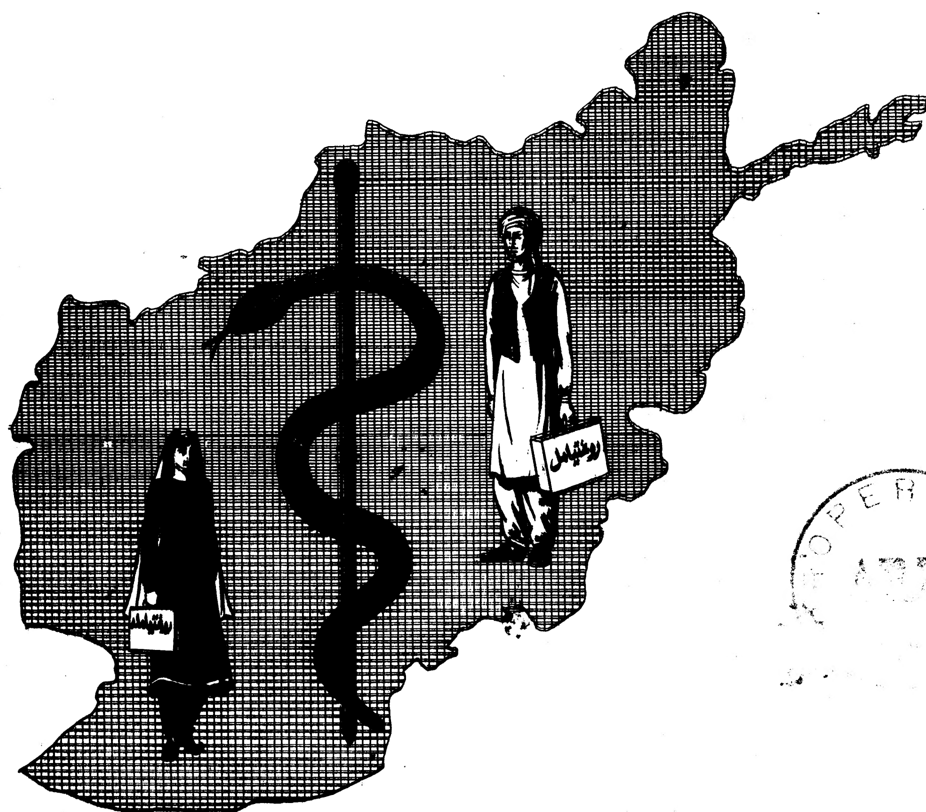
C. Training

The major principles for training VHWs are as follows:

(1) Training should be "competency based." This means that the VHWs should only be trained to competently and consistently perform those specific tasks we



REPUBLIC OF AFGHANISTAN
MINISTRY OF PUBLIC HEALTH



PRIMARY HEALTH CARE THROUGH VILLAGE HEALTH WORKERS

March 1977

A PROPOSED VILLAGE HEALTH WORKER PROGRAM
FOR
THE PEOPLE OF AFGHANISTAN

23 March 1977

Prepared under the Guidance and Instruction
of
His Excellency Professor Dr Abdullah Omar
Minister of Public Health

by
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With
Cooperation from The Management Team



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